

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10471

CERTIFICATE OF DEATH

10470

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>City 311</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>680 N. Milton Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>Barbara</b> First <b>Bangert</b> Middle <b>Bangert</b> Last		4. DATE OF DEATH <b>October 11 19 57</b> Month <b>October</b> Day <b>11</b> Year <b>57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-10-70</b>
9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Packing House</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph H. Lavin</b>		14. MOTHER'S MAIDEN NAME <b>Mary K. Kempal</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Sophie Cihlar</b> Address <b>524 N. Hilton Ave, Balto</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>11 months</b> (c) <b>11 years</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CBS arr. w/ disturbance of metabolism, growth + nutrition with</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Stroke brain disease</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 2, 1954</b> , to <b>October 11, 1957</b> , that I last saw the deceased alive on <b>October 11, 1957</b> , and that death occurred at <b>4:15 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Gertrud Sourenfeldt</b> M.D. <b>Springfield State Hospital Sykesville Md</b>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Gertrud Sourenfeldt M.D. Springfield State Hospital Sykesville Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>10-18-1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>HOLY REDEEMER</b>	22d. LOCATION (City, town, or county) (State) <b>BALTO. MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.R. CVIACI + SON 900 N. CHESTER ST</b>		24a. REC'D BY REGISTRAR <b>14 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Cherry Weers</b>	

CERTIFICATE OF DEATH

Name of Deceased		Joseph A. ...	
Residence		...	
Date of Death		8-10-52	
Place of Death		...	
Cause of Death		...	
Manner of Death		...	
Age		...	
Sex		...	
Race		...	
Marital Status		...	
Occupation		...	
Signature of Physician		...	
Signature of Registrar		...	

BUREAU V. 1

Oct 14 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10471

10472

## CERTIFICATE OF DEATH

Reg. Dist. No.

3374

1. PLACE OF DEATH a. COUNTY <b>Carroll County MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>5 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b> <i>03x2.2</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>May Pullen Nursing Home</b>				d. STREET ADDRESS <b>Main Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Rosa</b> Middle <b>Gore</b> Last <b>Beveridge</b>				4. DATE OF DEATH Month <b>October</b> Day <b>1</b> Year <b>19 57</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 6 1876</b>		9. AGE (In years last birthday) <b>81</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Hilleary B. Gore</b>				14. MOTHER'S MAIDEN NAME <b>Rebecca Conaway</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Marion B. Gore Westminster Md RD 6</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest, Cardiac failure,</b> <b>442x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, Hypertension.</b> DUE TO (c) <b>Chronic Brain Syndrome.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>April 57 to Oct 57</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>19 56</b> , 19 <b>57</b> , to <b>Sept</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>7 Oct</b> , 19 <b>57</b> , and that death occurred at <b>7:30 P M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Reisterstown, Md</b> DATE SIGNED <b>Oct 1 1957</b> ACTUAL SIGNATURE <b>Howard E. Hall</b> M.D. <b>H. E. Hall</b> PHYSICIAN'S NAME (Type) <b>Howard E. Hall</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct 4 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Reisterstown Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. B. Berryman + Son</b>				24a. REC'D BY REGISTRAR DATE <b>10 1-57</b>		24b. REGISTRAR'S SIGNATURE <b>Harry B. Shive</b> <b>C. Harry Sharp</b>	

# CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		1912		New York City		New York City		Heart Disease		October 1, 1957		10:00 AM		New York City		[Signature]		[Signature]	
Occupation		Marital Status		Education		Religion		Previous Illnesses		Medical History		Manner of Death		Burial or Disposition		Funeral Home		Cemetery		Burial Date		Burial Time	
Teacher		Married		High School		Catholic		Hypertension		None		Natural		Buried		St. John's		St. John's		October 2, 1957		12:00 PM	

BUREAU V. 2

OCT 7 1957

RECEIVED

10473

## CERTIFICATE OF DEATH

10472

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WOODBINE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RD. 3 WESTMINSTER</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WETZEL NURSING HOME</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELIAS BOLLINGER</u>				4. DATE OF DEATH Month Day Year <u>10-27-1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 16-1874</u>	9. AGE (In years last birthday) yrs. <u>83</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>GHIO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>WILLIAM BOLLINGER</u>				14. MOTHER'S MAIDEN NAME <u>LYDIA STUMP</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>JACOB BOLLINGER</u>		Address R. D. 3 <u>WESTMINSTER MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senility</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> <u>??</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 10, 1957</u> , to <u>Oct 27, 1957</u> , that I last saw the deceased alive on <u>Oct 27, 1957</u> , and that death occurred at <u>4:00 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>85 1/2 W. Green St. Westminister, MD.</u> DATE SIGNED <u>10/28/57</u>							
ACTUAL SIGNATURE <u>Julius Chepko</u>				PHYSICIAN'S NAME (Type) <u>Julius Chepko</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10-30-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WAYNE CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WOOD CO. OHIO</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>David A Bankard</u>				ADDRESS <u>Westminister Md</u>		24a. REC'D BY REGISTRAR DATE <u>10-29-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BUREAU V. S.

OCT 31 1957

RECEIVED

10474

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Taneytown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Blanche</b> Last <b>BOSLEY</b>				4. DATE OF DEATH Month <b>October</b> Day <b>9</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 2, 1886</b>		9. AGE (In years last birthday) yrs. <b>71</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David Bosley</b>				14. MOTHER'S MAIDEN NAME <b>Angelin Bowen</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage of stomach due to ulcer</b>							<b>Acute</b>
560.4 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Diaphragmatic hernia</b>							<b>Congenital</b>
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic reaction, paranoid type.</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1, 1950</b> to <b>October 9, 1957</b> , that I last saw the deceased alive on <b>October 9, 1957</b> , and that death occurred at <b>7:30 P. M.</b> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b> M.D.				<b>Springfield State Hospital</b> <b>10/10/57</b>			
PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M.D.</b>				<b>Sykesville, Maryland.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>Oct 14, 1957</b>		<b>Finksburg Methodist</b>		<b>Finksburg, Carroll, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Berryman &amp; Sons</b>				ADDRESS <b>Reisterstown, Md.</b>		24a. REC'D BY REGISTRAR <b>10-12-57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Harry S. Davis</b>		<b>Carroll County</b>	

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# CERTIFICATE OF DEATH

BUREAU V. S.

OCT 16 1957

RECEIVED



10475

## CERTIFICATE OF DEATH

10474

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> o. COUNTY <b>Carroll</b> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 2, Md</b> <b>3401.4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>29 Albermarle Street</b>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>Rubin Botwinik</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>10 26 1957</b>	
<b>5. SEX</b> <b>M</b>	<b>6. COLOR OR RACE</b> <b>W</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>1900</b>
<b>9. AGE</b> (In years last birthday) <b>57</b> yrs.		<b>IF UNDER 1 YEAR</b> <b>IF UNDER 24 HRS.</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>dye</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Paul</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Miriam</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>UNKN</b>		<b>16. SOCIAL SECURITY NO.</b> <b>UNKN</b>	
<b>17. INFORMANT</b> <b>S.S. Hospital Records</b>		<b>Address</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Coronary Occlusion</b> <b>420.0</b> DUE TO <b>(b) Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>(c) Arteriosclerotic heart disease</b>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <b>Chr. brain syndr. assoc. with cerebral arteriosclerosis with psych. rea ct.</b> <b>Chronic nephritis</b>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)	
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <b>19</b>	
<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b>		<b>(County)</b> <b>(State)</b>	
<b>21. I certify that I attended the deceased from</b> <b>10-19-57</b> , 19____, to <b>10-26</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>10-26</b> , 19 <b>57</b> , and that death occurred on <b>10-26</b> at <b>4:15 P.M.</b> , from the causes and on the date stated above. <b>ADDRESS</b> (Street, city or town, state) <b>DATE SIGNED</b> <b>Edmund Lusthaus</b> M.D. <b>Springfield State Hospital</b> <b>10-26-57</b> <b>ACTUAL SIGNATURE</b> <b>PHYSICIAN'S NAME (Type)</b> <b>Sykesville, Maryland.</b>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>10-27-57</b>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Herring Run</b>		<b>22d. LOCATION (City, town, or county)</b> <b>(State)</b> <b>Baltimore Md</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Jack Lewin Inc</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>10/26/57</b>	
<b>ADDRESS</b> <b>2100 Euterpe Pl</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>C. Hays</b>	

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

OCT 29 1957

RECEIVED

10476

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>4yrs.7mos.10days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>3714 Kimble Road, Zone 18</b>	
3. NAME OF DECEASED (Type or print) First <b>Genevieve</b> Middle <b>Estelle</b> Last <b>GILL BRADLEY</b>		4. DATE OF DEATH Month <b>October</b> Day <b>14</b> , Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 2, 1873</b>
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR: Months <b>84</b> Days <b>84</b> Hours <b>84</b> Min <b>84</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown Charles GILL</b>		14. MOTHER'S MAIDEN NAME <b>Unknown Alice Ridgely</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease.</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>Bronchopneumonia</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with dist. of metabolism, growth or nutrition, with senile brain disease, with psychotic reaction.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>Days</b>
19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour <b>19</b> Month, Day, Year p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 4, 1953</b> to <b>October 14, 1957</b> that I last saw the deceased alive on <b>October 14, 1957</b> and that death occurred at <b>7:40 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edmund Lusthaus</b> M.D.		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>10/15/57</b>	
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>		<b>Sykesville, Maryland.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-17-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>MORELAND PARK</b>	22d. LOCATION (City, town, or county) (State) <b>BALTO MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck</b>		ADDRESS <b>5305 Harford Rd</b>	
24a. REC'D BY REGISTRAR <b>10/15/57</b>		24b. REGISTRAR'S SIGNATURE <b>L. Harry Keer</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 10 1907

RECEIVED

## CERTIFICATE OF DEATH

10477

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <b>Sykesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>726 Batrlett Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Francis</b> Middle <b>Joseph</b> Last <b>Burger</b>		4. DATE OF DEATH Month <b>10</b> Day <b>5</b> Year <b>1957</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2 - 21 - 85</b>
9. AGE (In years last birthday) <b>72 yrs.</b>		10. IF UNDER 1 YEAR Months <b>12</b> Days <b>12</b> Hours <b>12</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stationary engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Louis Burger</b>		14. MOTHER'S MAIDEN NAME <b>Mary Carroll</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-03-2860</b>	
17. INFORMANT <b>S.S. Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Bilateral pneumonitis</b> <b>12 X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Rheumatic heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chr. brain syndr. assoc. with cerebral arteriosclerosis with psych. react.</b>			INTERVAL BETWEEN ONSET AND DEATH weeks <b>years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>7 - 8 - 1957</b> , to <b>10 - 5 - 1957</b> , that I last saw the deceased alive on <b>10-5-1957</b> , and that death occurred at <b>11:15 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edmund Lusthaus</b>		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>	
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus</b>		DATE SIGNED <b>10-6-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>10/9/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>CATHEDRAL</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edmund Lusthaus</b>		24a. REC'D BY REGISTRAR DATE <b>10/11/57</b>	
24b. REGISTRAR'S SIGNATURE <b>C. Harry King</b>			

1 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

2 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. S.

NOT 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10478

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10477  
74

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>6yrs. 7mos. 2days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>May Ray Harris CARUSO</b>		4. DATE OF DEATH Month Day Year <b>October 9, 1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>1889</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR Months Days <b>68</b>	11. IF UNDER 24 HRS. Hours Min. <b>68</b>
10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) <b>Tailoring Co.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John W. Harris</b>		14. MOTHER'S MAIDEN NAME <b>Frances Guy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Syphilitic Aortitis involving coronary arteries</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Psychosis with syphilitic meningo-encephalitis.</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>hours</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Was found on floor by bed unconscious.</b>	
20c. TIME OF INJURY Month, Day, Year <b>7:30 AM 10/9/57 19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>		20f. (City or town) (County) (State) <b>Sykesville Carroll Maryland</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>James T. Marsh</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>James T. Marsh, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>10/10/57</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 12/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Peters Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. H. W. T. K.</i>		ADDRESS <b>4101 E. Dunes Ave BAL. MD</b>	
24a. REC'D BY REGISTRAR <b>OCT 15 1957</b>		24b. REGISTRAR'S SIGNATURE <i>Harry Weiss</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

OCT 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10478

10479

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville, Md. (rural)</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring, Md.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Mary Giallobardo Crivella</b>				4. DATE OF DEATH Month <b>October</b> Day <b>5</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-12-1888</b>	9. AGE (In years last birthday) <b>69</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Italy</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A. (naturalized)</b>							
13. FATHER'S NAME <b>Mario Giallobardo (deceased)</b>				14. MOTHER'S MAIDEN NAME <b>Mary Grace Ditta (deceased)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>Not known</b>		17. INFORMANT Address <b>Washington, D. C.</b> <b>Josephine LaMendola, 3955 Blaine St., N. E.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>470.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart Disease</b> (c) <b>Generalized Arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>years</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>May 14, 1956</b> to <b>Oct. 5, 1957</b> , that I last saw the deceased alive on <b>Oct. 5, 1957</b> , and that death occurred at <b>11 A. M.</b> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>Springfield State Hospital Sykesville, Md.</b> DATE SIGNED							
ACTUAL SIGNATURE <b>Gerard Sounefeldt M.D.</b>							
PHYSICIAN'S NAME (Type) <b>Gerard Sounefeldt M.D. Springfield State Hospital Sykesville, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>10-9-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Timothy Haulon</b>				ADDRESS <b>3831 - La Ave NW</b>		24a. REC'D BY REGISTRAR DATE <b>8 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>C. Harry Sheers</b>			

BUREAU V. S.

OCT 9 1937

RECEIVED



10480

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>		c. LENGTH OF STAY IN 1b <b>4,751 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> 3 v . . . 4	
f. STREET ADDRESS <b>1326 Myrtle Avenue</b>		• 15. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Jane Elizabeth Day</b>		4. DATE OF DEATH Month Day Year <b>October 18 19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-1-1941</b>
9. AGE (In years last birthday) <b>16 yrs</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James E. Day</b>		14. MOTHER'S MAIDEN NAME <b>Nancy Green</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Nancy Day - Mother - 1326 Myrtle Avenue</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Far advanced bilateral cavitory pulmonary Tbc.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cor Pulmonale</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>13 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10-15-</b> 19 <b>44</b> , to <b>10-18</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>10-18</b> , 19 <b>57</b> , and that death occurred at <b>2 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Henryton, Maryland 10-18-57</b>			
ACTUAL SIGNATURE _____ M.D.		Henryton, Maryland	
PHYSICIAN'S NAME (Type) <b>Edgars M. Maculans, M.D. Supt.</b>		<b>Henryton State Hospital</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank D. Newell, Pikesville, Md.</b>		24a. REC'D BY REGISTRAR <b>Albert R. Swann</b>	
24b. REGISTRAR'S SIGNATURE		DATE	

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

OCT 22 1957

BUREAU V. 3

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10480

10481

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b> City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>6yrs. 1mo. 21days.</b> <b>Baltimore</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Estelle</b> Middle <b>Viola</b> Last <b>DEVEREAUX</b>				4. DATE OF DEATH Month <b>October</b> Day <b>15</b> Year <b>19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 6, 1877</b>	
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chiroprapist</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Michael Devereaux</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Crane</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT Address <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rheumatic heart disease</b> DUE TO (b) <b>Bronchopneumonia</b> DUE TO (c) <b>Senile psychosis with simple deterioration and generalized arterio-sclerosis. Intertrochanteric fracture, right femur.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT ON GIVEN IN PART I (a) <b>Senile psychosis with simple deterioration and generalized arterio-sclerosis. Intertrochanteric fracture, right femur.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>3 days</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <b>Unknown</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>2:PM</b> o. m. <b>10/7/57</b> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>		20f. (City or town) (County) (State) <b>Sykesville Carroll Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>James T. Marsh</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>James T. Marsh, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL-CREATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>10/18/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>CATHEDRAL</b>		22d. LOCATION (City, town, or county) (State) <b>DALTO</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frederick J. Son</b>				ADDRESS <b>Balto.</b>		24a. REC'D BY REGISTRAR DATE <b>10/18/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>C. Harry Myers</b>			

MEDICAL CERTIFICATION

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for use by the Chief Medical Examiner's Office along with form P-103. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

OCT 21 1955

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10482 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10481

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto. City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>1yr. 12days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>Bonn</u> Last <u>Ferris</u> <u>DEWLING</u>				4. DATE OF DEATH Month <u>October</u> Day <u>10</u> Year <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. <u>WIDOWED</u>		8. DATE OF BIRTH <u>October 1, 1873</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Ferris</u>				14. MOTHER'S MAIDEN NAME <u>Anna Simms</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-24-5304</u>		17. INFORMANT <u>Springfield Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO (b) <u>Arteriosclerotic cardiovascular disease.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>904.7</u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.B.S. associated with senile brain disease with psychotic reaction.</u> <u>Fracture of left femur.</u>							INTERVAL BETWEEN ONSET AND DEATH Hours <u>  </u> Years <u>  </u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Slipped and fell.</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>9/3/57</u> 19 p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>No</u>		20f. (City or town) (County) (State) <u>Sykesville Carroll Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James T. Marsh</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
James T. Marsh, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>10/12/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Am J. Dickner &amp; Sons. Balto</u>				ADDRESS <u>  </u>		24a. REC'D BY REGISTRAR DATE <u>11/1/57</u>	
24b. REGISTRAR'S SIGNATURE <u>C. Harvey Harris</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



BUREAU V. S.

OCT 11 1957

RECEIVED

10483

## CERTIFICATE OF DEATH

10482

Reg. Dist. No. 76A

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Union Mills Md</u>				c. LENGTH OF STAY IN 1b <u>3 weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>THOMAS - HAVERN GILL</u>				4. DATE OF DEATH Month Day Year <u>Oct 19 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 17 - 1887</u>	9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>R Stephen Gill</u>				14. MOTHER'S MAIDEN NAME <u>Aurice Six</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>219-12-2411</u>		17. INFORMANT Address <u>Mrs Wm Auer Hauptstead Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dissecting aortic aneurysm Aorta</u> 4.2.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio sclerosis C-V disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>9-23</u> 19 <u>57</u> to <u>10-19-57</u> , that I last saw the deceased alive on <u>10-19</u> 19 <u>57</u> , and that death occurred at <u>3:45</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James J. Marsh</u> M.D.				ADDRESS (Street, city or town, state) <u>105 E Main St</u> DATE SIGNED <u>10-19-57</u>			
PHYSICIAN'S NAME (Type) <u>JAMES T. MARSH</u>				<u>Westminster Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 22/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hauptstead</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Edw E. Tipton Hauptstead Md</u>				24a. REC'D BY REGISTRAR DATE <u>Oct. 22. 57</u>		24b. REGISTRAR'S SIGNATURE <u>Louise M. Enigh</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

OCT 24 1957

BUREAU V. S.

1  
INSTRUCTIONS  
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.  
The bottom copy may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.  
VS A15C 1-55 10M

CERTIFICATE OF DEATH

10434

Reg. Dist. No. 33

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>		TOWN <u>Reisterstown</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Union Mills</u>		LENGTH OF STAY (in this place) <u>7 months</u>		STREET ADDRESS <u>Meadow View Nursing Home</u>		(If rural give location) <u>Main Street</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Rembert DeCarroll Gore</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>October 15 1957</u>			
5. SEX <u>M</u>		6. CO. OR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>December 17 1878</u> <u>78</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Surveyor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md State Roads</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Lewis D Gore</u>				14. MOTHER'S MAIDEN NAME <u>Martha E Frazier</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs Inez C Horine RFD 5 Westmins ter Md</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
447x IMMEDIATE CAUSE (A) <u>Cardio Vascular Renal Disease</u>				<u>Pneumonia</u>		<u>Sept 30/57</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>C Hypertension &amp; arteriosclerosis</u>				<u>Multiple Bed Sores</u>		<u>yes</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Fracture Left Hip</u>						<u>May 19 57</u>	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 19 56</u> to <u>Oct 15 57</u> , that I last saw the deceased alive on <u>Oct 14 19 57</u> , and that death occurred at <u>7:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>W. L. Speicher</u> M.D.				ADDRESS (Street, city, town, state) <u>Westminster Md</u>		DATE SIGNED <u>10/15/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct 18 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		LOCATION (City, town, or county) <u>Pikesville Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Anna B. Straub</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Berryman &amp; Sons</u>		ADDRESS <u>Reisterstown Md</u>	
DATE <u>10-15-57</u>							

BUREAU V. S.

OCT 22 1957

RECEIVED



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10485

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 87

10484

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE RURAL</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE RURAL</u>			
c. LENGTH OF STAY IN 1b <u>YEARS</u>				d. STREET ADDRESS <u>1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANKLIN DENNIS HAHN</u>				4. DATE OF DEATH Month Day Year <u>OCT 27 1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 25 - 1953</u>	
9. AGE (In years last birthday) <u>4</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>FRANKLIN D HAHN</u>				14. MOTHER'S MAIDEN NAME <u>FLORA FRANCIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>NONE</u>		17. INFORMANT Address <u>FRANKLIN HAHN UNION BRIDGE RURAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>500X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>acute laryngo-tracheo-bronchitis</u> DUE TO (c) <u>Upper Respiratory Infection</u>							INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>OCT 26</u> , 1957, to <u>OCT 27</u> , 1957, that I last saw the deceased alive on <u>OCT 26</u> , 1957, and that death occurred at <u>6:10 A.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>E. Quibler Thompson M.D.</u>				Janesville, Md.			
NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>OCT 29 - 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HAUGHS</u>		22d. LOCATION (City, town, or county) (State) <u>FREDERICK CO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DD Hartzler Sons Union Bridge</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>10-28-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Paul A. Kephart</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 29 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10486

## CERTIFICATE OF DEATH

Reg. Dist. No. 10485 74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Md.</u>			
c. LENGTH OF STAY IN 1b <u>2 y 1 m 5 d</u>				d. STREET ADDRESS <u>1468 William Street</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Hawk</u> Last <u>Hawk</u>				4. DATE OF DEATH Month <u>10</u> Day <u>4</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <u>SEPARATED</u> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/1/1892</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unkn Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Meat Store</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Edward Hawk</u>				14. MOTHER'S MAIDEN NAME <u>Ella Gardner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes Navy</u>		16. SOCIAL SECURITY NO <u>unkn</u>		17. INFORMANT <u>S.S. Hospital Records</u> Address <u>  </u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <u>Inanition</u> DUE TO <u>Septicemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b). <u>  </u> DUE TO <u>Decubitus ulcers</u> (c). <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH weeks <u>  </u> weeks <u>  </u> weeks <u>  </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u>Chr. brain syndr. assoc. with Huntington chorea, with psych. reaction</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-29-55</u> , 19 <u>  </u> , to <u>10-4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10-4</u> , 19 <u>57</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edmund Lusthaus</u>				ADDRESS (Street, city or town, state) <u>M.D. Springfield State Hospital</u>		DATE SIGNED <u>10-4-57</u>	
PHYSICIAN'S NAME (Type) <u>Edmund Lusthaus</u>				<u>Sykesville, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/3/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN F. DENNY, INC. 715 Light St.</u>				24a. REC'D BY REGISTRAR <u>  </u> DATE <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry Karp</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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OCT 9 1961

BUREAU V. S.

10487 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8, Film G-222-11/12/11

10521

Reg. Dist. No.

1. PLACE OF DEATH  
a. COUNTY Carroll MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy

c. LENGTH OF STAY IN 1b 2 mo.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
a. STATE Florida b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jacksonville 48-1

d. STREET ADDRESS 3241 Thomas St.,

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Middle Last EUNICE ELY HUBBARD

4. DATE OF DEATH Month Day Year OCT. 26, 1957

5. SEX female 6. COLOR OR RACE white 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 8. DATE OF BIRTH 1-17-1891 9. AGE (In years last birthday) 66 yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework 10b. KIND OF BUSINESS OR INDUSTRY home 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Edwin N. Ely 14. MOTHER'S MAIDEN NAME Blanche Harrison

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 219-28-5654 17. INFORMANT Address Mrs. Marion Harris, Mt. Airy, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Heart Disease Sudden  
11-20-11 DUE TO  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 25, 1957, to Oct 26, 1957, that I last saw the deceased alive on Oct 25, 1957, and that death occurred at 12 M, from the causes and on the date stated above.

SIGNATURE C. M. Van Poole M.D. ADDRESS (Street, city or town, state) Mt. Airy Md DATE SIGNED 10-26-57

PHYSICIAN'S NAME (Type) C. M. Van Poole

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF 10-29-1957 22c. NAME OF CEMETERY OR CREMATORY Woodlawn 22d. LOCATION (City, town, or county) (State) Woodlawn, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, ADDRESS Winfield, Maryland 24a. REC'D BY REGISTRAR DATE OCT 28 1957 24b. REGISTRAR'S SIGNATURE Edna Smith

CHAMPLAIN V. S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with in 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with in 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10488

## CERTIFICATE OF DEATH

10488  
Reg. Dist. No. 14

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville Md. (rural)</b> c. LENGTH OF STAY IN 1b <b>1 y 1 m</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, Maryland</b> d. STREET ADDRESS <b>205 W. Madison St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Esther</b> Middle <b>Hunt</b> Last <b>Hunt</b>		4. DATE OF DEATH Month <b>10</b> Day <b>8</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1862</b>
9. AGE (In years last birthday) yrs <b>95</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>never employed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel Hunt</b>		14. MOTHER'S MAIDEN NAME <b>Martha Beall</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>not known</b>	
17. INFORMANT <b>Wm. Wright, trustee</b>		Address <b>Birmingham, Ala.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Uremia</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Nephrosclerosis arteriosclerotic heart disease</b> DUE TO (c) <b>Chronic brain syndrome associated with disturbance of metabolism, growth or nutrition with senile brain disease with psychotic reaction.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>months</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>8-22</b> , <b>1956</b> to <b>10-8</b> , <b>1957</b> , that I last saw the deceased alive on <b>10-8</b> , <b>1957</b> , and that death occurred at <b>3 P.</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Gerhard Soumireu M.D.</b>		ADDRESS (Street, city or town, state) <b>Springfield State Hospital Sykesville Md.</b>	
NAME (Type) <b>Gerhard Soumireu M.D.</b>		DATE SIGNED <b>Springfield State Hospital Sykesville Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 11, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook, Inc.</b>		ADDRESS <b>1217 St. Paul St.</b>	
24a. REC'D BY REGISTRAR <b>10 9-57</b>		24b. REGISTRAR'S SIGNATURE <b>C. Harry Tiller</b>	

BUREAU V. S.

OCT 14 1957

RECEIVED



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10489

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll County</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodbine, Md.</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Gosnell Nursing Home</b>				d. STREET ADDRESS <b>6525 Maplewood Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>LOUISE</b> Middle <b>H.</b> Last <b>JACOB</b>				4. DATE OF DEATH Month <b>Oct</b> Day <b>7</b> Year <b>1957</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 22, 1862</b>	
9. AGE (In years last birthday) yrs <b>95</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Germany</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>John Bartell</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Mrs. Mamie Leiman, 4803 Frederick Avenue</b>				Address			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest, Cardiac failure,</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerotic heart disease, abnormal</b> DUE TO (c) <b>aneurysm.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1956 to Oct 1957</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>1956</b> , 19 <b>7 Oct</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>7 Oct</b> , 19 <b>57</b> , and that death occurred at <b>10:45 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Howard E. Hill</b>				M.D. <b>Spesville, Md</b> <b>7 Oct 57</b>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-10-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>10/9/57</b>	
24b. REGISTRAR'S SIGNATURE <b>Edna Kuntz</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU W. 91

OCT 10 1957

RECEIVED  
OCT 10 1957

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TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The death certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M-1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

10488

Reg. Dist. No. 76

10490

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Finksburg</u> <u>Carroll</u> <u>MARYLAND</u>				STATE <u>Maryland</u> COUNTY <u>Carroll</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
TOWN <u>Finksburg,</u>		<u>8 years</u>		TOWN <u>Finksburg, Maryland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Finksburg, Maryland</u>				STREET ADDRESS (If rural give location) <u>None</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Frances Evelyn Jones</u>				<u>10 - 16 - 19 57</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>9-11-1877</u>	<u>80</u> yrs.	Months	Days	Hours   Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>				<u>Carroll Co. Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME <u>Francis W. Reese</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Jane Coppersmith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>No</u>		<u>Thomas S. Jones Finksburg, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis 12 hours</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Cardio-Vascular</u>						<u>5 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Disease</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8-11-52</u> 19 <u>52</u> to <u>10-16-</u> 19 <u>57</u> , that I last saw the deceased alive on <u>10-15</u> 19 <u>57</u> , and that death occurred at <u>4:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Martin E. Strodel</u>				ADDRESS (Street, city, town, state) <u>48 Main Street Reisterstown, Maryland</u>			
DATE <u>10-19-57</u>				DATE SIGNED <u>10-16</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10-19-57</u>		NAME OF CEMETERY OR CREMATORY <u>Deer Park Cemetery</u>		LOCATION (City, town, or county) (State) <u>Westminster, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Harriet Miller</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr.</u>		ADDRESS <u>Westminster, Md.</u>	

BUREAU V. S.

OCT 21 1977

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10491

## CERTIFICATE OF DEATH

Reg. Dist. No. 104894

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>1 month</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>3V01.4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>2623 Guilford Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Cecelia Geneveive King KANE</b>				4. DATE OF DEATH Month Day Year <b>October 24, 1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 20, 1870</b>		9. AGE (In years last birthday) yrs. <b>87</b>	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas King</b>				14. MOTHER'S MAIDEN NAME <b>Sara Conroy</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT Address <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>440.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senile psychosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>September 26, 1957</b> , to <b>October 24, 1957</b> , that I last saw the deceased alive on <b>October 23, 1957</b> , and that death occurred at <b>5:15 A. M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>10/24/57</b> ACTUAL SIGNATURE <b>Edmund Lusthaus</b> M.D. PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b> <b>Sykesville, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		22b. DATE THEREOF <b>10-26-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Catholic</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook Inc</b> ADDRESS <b>1517 N. Paul St.</b>				24a. REC'D BY REGISTRAR DATE <b>10-24-57</b>		24b. REGISTRAR'S SIGNATURE <b>C. H. H. H.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

OCT 28 1957

RECEIVED

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10492

10492

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>1yr. 1mo. 4days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Frederick KEISER, Jr.</b>		4. DATE OF DEATH Month Day Year <b>October 29, 1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>September 3, 1899</b>
9. AGE (In years last birthday) <b>58</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min <b>58</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Truck</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Keiser</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth (Keiser) Polheim</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>744</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>974 Suicide by hanging</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Psychotic depressive reaction.</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Suicide by hanging.</b>	
20c. TIME OF INJURY Month, Day, Year <b>5:20PM 10/29/ 1957</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>	20f. (City or town) (County) (State) <b>Sykesville Carroll Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James T. Marsh</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>James T. Marsh, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>10/29/57</b>	
22a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-2-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Western Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>		24. REC'D BY REGISTRAR DATE <b>10/30/57</b>	
24b. REGISTRAR'S SIGNATURE <b>C. Harry Wain</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Registrar of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Items 9, File 3221, 10/24/57 reg  
10493  
CERTIFICATE OF DEATH

10491  
Reg. Dist. No.

1 PLACE OF DEATH a COUNTY <u>Carroll</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Carroll</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester (Rural)</u>		c LENGTH OF STAY IN 1b <u>2 yrs</u>	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d STREET ADDRESS	
3 NAME OF DECEASED (Type or print) <u>JOHN-LOUISO - KNIGHT</u>		4 DATE OF DEATH Month <u>Oct</u> Day <u>12</u> Year <u>1957</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>May 21, 1906</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b KIND OF BUSINESS OR INDUSTRY <u>General</u>	9 AGE (In years last birthday) <u>51 yrs</u>
11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>John L Knight</u>		14 MOTHER'S MAIDEN NAME <u>Bertha Prieschel</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16 SOCIAL SECURITY NO <u>225-05-0485</u>	
17 INFORMANT <u>Madeline Knight, Manchester, Md</u>		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Left Lung</u> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9/26</u> 19 <u>57</u> , to <u>10/12</u> 19 <u>57</u> , that I last saw the deceased alive on <u>10/7</u> 19 <u>57</u> , and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W H Foard</u>		DATE SIGNED <u>10/12/57</u>	
PHYSICIAN'S NAME (Type) <u>W. H. Foard M.D.</u>		ADDRESS (Street, city or town, state) <u>Manchester, Md</u>	
22a BURIAL, CREMATION, REMOVAL (Specify)	22b DATE THEREOF <u>10.14.57</u>	22c NAME OF CEMETERY OR CREMATORY <u>Calver Hall School</u>	22d LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23 FUNERAL DIRECTOR'S SIGNATURE <u>Edwin E Tipton</u>		24a REC'D BY REGISTRAR <u>10/14/57</u>	24b REGISTRAR'S SIGNATURE <u>Thos M. H. [unclear]</u>

RECEIVED

OCT 16 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10492

10494

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Westminster</b> c. LENGTH OF STAY IN b. <b>life</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X/ Rural Westminster</b> d. STREET ADDRESS <b>/</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Flora Ida Koontz</b>		4. DATE OF DEATH Month Day Year <b>October 16, 1957</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 26, 1865</b>
9. AGE (In years last birthday) <b>91</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <b>91</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Valentine C. Wentz</b>		14. MOTHER'S MAIDEN NAME <b>Lydia Harman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Mrs. Bertha Myers, Westminster, Md. R.D.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerotic Coronary Vascular Renal Disease</b> DUE TO (c) <b>years.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Early Bladder Disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 1954</b> to <b>Oct 6, 1957</b> that I last saw the deceased alive on <b>Oct. 16, 1957</b> , and that death occurred at <b>10:15 PM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <b>148 W Main, Westminster 10/17/57</b>	
ACTUAL SIGNATURE <b>G. Allen Moulton</b> PHYSICIAN'S NAME (Type) <b>G. ALLEN MOULTON, M.D.</b> <b>WESTMINSTER, MD.</b>		M.D. <b>148 W Main, Westminster</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/20/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Valley Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pleasant Valley, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Merwyn C. Fuss</b> ADDRESS <b>Taneytown, Maryland</b>		24a. RECEIVED BY REGISTRAR DATE <b>OCT 21 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Robert M. Mullen</b>			

BUREAU V. I.

OCT 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1049376

10495

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster,</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>William</u> Last <u>Lawyer</u>			4. DATE OF DEATH Month <u>October</u> Day <u>30</u> Year <u>19 57</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 9, 1887</u>		9. AGE (In years last birthday) yrs. <u>69</u>		IF UNDER 1 YEAR Months <u>30</u> Days <u>19</u> Hours <u>57</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Schoolteacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public School</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William E. Lawyer</u>				14. MOTHER'S MAIDEN NAME <u>Louisa Powell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>219-20-0791</u>		17. INFORMANT <u>Mrs. J. William Lawyer, Westminster, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage (3rd)</u> <u>4222</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocarditis (chr) nephrosis (chr)</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month <u>19</u> Hour <u>a. m.</u> Day <u>19</u> Year <u>1957</u>			20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May, 1945</u> , to <u>10-30-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>10-30-</u> , 19 <u>57</u> , and that death occurred at <u>6</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. C. Tennant</u>			M.D. <u>103 E Main Westminster Md.</u>		DATE SIGNED <u>11-2-57</u>		
PHYSICIAN'S NAME (Type) <u>W. C. Tennant</u>			<u>Westminster Md.</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 2, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Church of God Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Uniontown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Merwyn C. Fuss</u>				ADDRESS <u>Merwyn C. Fuss, Taneytown, Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 4 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>			

BUREAU V. S.

NOV 4 - 1957

RECEIVED

## CERTIFICATE OF DEATH

10496

Reg. Dist. No. 10494 74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>1 y 6 m 2 d</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 24, Md.</b>			
f. STREET ADDRESS <b>125 Cheapside Syreet</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Leslie</b> Last <b>Maddox</b>				4. DATE OF DEATH Month <b>10</b> Day <b>18</b> Year <b>19 57</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>11-28-01</b>		9. AGE (In years last birthday) <b>55</b> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>welder</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>William Maddox</b>				14. MOTHER'S MAIDEN NAME <b>Ana Mc Clellan</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>1921-22 218-05-0571</b>		17. INFORMANT <b>S.S. Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchopneumonia bilateral</b>							<b>days</b>
DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) <b>Far advanced Pulmonary Tuberculosis</b>							<b>years</b>
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chr. brain syndr. assoc. with centr. nerv. system syphilis, meningoencephalitic with psychotic reaction</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>4-16-1956</b> , to <b>10-18-1957</b> , that I last saw the deceased alive on <b>10-18-1957</b> , and that death occurred <b>8:19 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Edmund Lusthaus</b>				ADDRESS (Street, city or town, state) <b>M.D. Springfield State Hospital</b>			
DATE SIGNED <b>10-19-57</b>							
PRINTED NAME (Type) <b>Edmund Lusthaus</b> <b>Sykesville, Maryland.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>10/22/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>EDENEZER CEMT</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO. Co. MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Clarence F. Hoffman</b>				ADDRESS <b>3218 Hudson St</b>		24a. REC'D BY REGISTRAR <b>DATE 10-23-1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Harry Myers</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 23 1957

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10497

## CERTIFICATE OF DEATH

Reg. Dist. No.

104954

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
c. LENGTH OF STAY IN 1b <b>3mos. 14days</b>		d. STREET ADDRESS <b>1212 W. 37th St., Zone 11</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>Allen</b> Last <b>MILLER</b>		4. DATE OF DEATH Month <b>October</b> Day <b>23</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 2, 1880</b>
9. AGE (In years last birthday) <b>77</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Factory worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cotton Duck Mill</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Miller</b>		14. MOTHER'S MAIDEN NAME <b>Susan <del>Miller</del> Masenheimer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>513-05-0502</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. due to cerebral arteriosclerosis, plus psychosis</b> <b>HYPERTENSION</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 9, 1957</b> , to <b>October 23, 1957</b> , that I last saw the deceased alive on <b>October 23, 1957</b> , and that death occurred at <b>1:45 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>10/23/57</b> ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b> M.D. PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M.D.</b> <b>Sykesville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Oct. 26, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's (Hampden)</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. Verner</b>		24a. REC'D BY REGISTRAR <b>464 Park Heights</b>	
24b. REGISTRAR'S SIGNATURE <b>Harry Myers</b>		DATE <b>OCT 25 1957</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
OCT 25 1967  
BUREAU V. S.

CERTIFICATE OF DEATH

10498  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>1306 Belvedere Boulevard</b>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Henry</b> Last <b>MILLER</b>		4. DATE OF DEATH Month <b>October</b> Day <b>22</b> , Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 27, 1865</b>
9. AGE (In years last birthday) <b>92</b> yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>R.R. Car inspector</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Miller</b>		14. MOTHER'S MAIDEN NAME <b>Lena Miller JOY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>none</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>4-2-0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <b>C.B.S. assoc. with dist. of metabolism, growth or nutrition, with senile brain disease, with psychotic reaction.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 1, 1957</b> , to <b>October 22, 1957</b> , that I last saw the deceased alive on <b>October 22, 1957</b> , and that death occurred at <b>1:15 P.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>Walther H. Sonnenfeldt, M.D. Springfield State Hospital 10/22/57</b>			
22. ACTUAL SIGNATURE (Type) <b>Walther H. Sonnenfeldt, M.D.</b> <b>Sykesville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>10/25/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Prince George County, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Werner E. Murphy</b>		24a. REC'D BY REGISTRAR <b>25 1957</b>	
ADDRESS <b>Silver Spring, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>C. Harry Henry</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

OCT - 1957

BUREAU V. S.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

78

10499

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural--Westminster</b> c. LENGTH OF STAY IN 1b <b>15 mo.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural--Westminster, R.D. 6</b> d. STREET ADDRESS <b>/</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JESSE EARL MORGAN</b>		4. DATE OF DEATH Month Day Year <b>OCT. 2, 1957</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-23-1887</b>
9. AGE (In years, months, and days) <b>70 yrs</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter (retired)</b>	11. BIRTHPLACE (State or foreign country) <b>Ohio</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Albert Morgan</b>	
14. MOTHER'S MAIDEN NAME <b>Fannie Stevens</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>220-14-4528</b>		17. INFORMANT Address <b>Mrs. Matilda Morgan, same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>7 mo</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James T. Marsh</b> EXAMINER'S NAME (Type) <b>JAMES T. MARSH</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>10-5-1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Poplar Springs</b>		22d. LOCATION (City, town, or county) <b>Howard Co., Maryland</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz,</b> ADDRESS <b>Winfield, Maryland</b>		24a. REC'D BY REGISTRAR <b>OCT 4 1957</b> 24b. REGISTRAR'S SIGNATURE <b>W. J. J. J.</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please  
 execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page  
 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,  
 or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 7 1900

RECEIVED

10500

## CERTIFICATE OF DEATH

10498

Reg. Dist. No. 14

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) iii. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>2yrs. 7mos.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>			
f. STREET ADDRESS <b>609 Sligo Creek Parkway</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Kate</b> Middle <b>Nave</b> Last <b>MURPHY</b>				4. DATE OF DEATH Month <b>October</b> Day <b>14</b> Year <b>19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 22, 1870</b>	
9. AGE (In years last birthday) <b>87 3/4</b> yrs.		IF UNDER 1 YEAR Months <b>3</b> Days <b>14</b> Hours <b>57</b> Min		IF UNDER 24 HRS Months <b>3</b> Days <b>14</b> Hours <b>57</b> Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>School</b>		11. BIRTHPLACE (State or foreign country) <b>Indiana</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Christian Addison Nave</b>				14. MOTHER'S MAIDEN NAME <b>Ella Mathers</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>unk</b>			
17. INFORMANT <b>Springfield Hospital Records</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Due to</b> (c) <b>Due to</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with dist. of metabolism, growth or nutrition, with senile brain disease, with psychotic reaction, Cellulitis, left knee.</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>March 14, 1955</b> , to <b>October 14, 1957</b> , that I last saw the deceased alive on <b>October 14, 1957</b> , and that death occurred at <b>10:15 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b> M.D.				ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>			
DATE SIGNED <b>10/14/57</b>							
PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M.D.</b>				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town or county) (State)	
<b>Cremation</b>		<b>10-16-57</b>		<b>Shoat Lincoln</b>		<b>Washington D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur D. Haight</b>				ADDRESS <b>Sykesville, Md.</b>			
24a. REC'D BY REGISTRAR <b>DATE 10-15-57</b>				24b. REGISTRAR'S SIGNATURE <b>C. Harry</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 19 1917

RECEIVED



## CERTIFICATE OF DEATH

Reg. Dist. No. 174

10501

1 PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>7 GERANIUM PLACE</u>	
c. LENGTH OF STAY IN 1b <u>6 mos.</u>		d. STREET ADDRESS <u>BALTO 20 MD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Fuller Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELLA</u> <u>BRITTON</u> <u>PIERCE</u>		4. DATE OF DEATH Month Day Year <u>October</u> <u>20</u> <u>1957</u>	
5 SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/28/1861</u>
9. AGE (In years last birthday) <u>95</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public School</u>	
11. BIRTHPLACE (State or foreign country) <u>HOLLAND, NEW JERSEY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HENRY T. BRITTON</u>		14. MOTHER'S MAIDEN NAME <u>MAHALIA BRITTON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>JOHN D. PIERCE (SON)</u>		Address <u>7 GERANIUM PLACE BALTO 20 MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Sudden Aortic, arteriosclerotic heart</u> <u>4:00</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>disease, senile degeneration,</u> DUE TO (c) <u>bronchial pneumonia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 Oct 57</u> <u>TO</u> <u>27 Oct 57</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>WILK</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1 Oct</u> , 19 <u>57</u> , to <u>27 Oct</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>27 Oct</u> , 19 <u>57</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D.		ADDRESS (Street, city or town, state) <u>Sykesville, Md.</u> DATE SIGNED <u>27 Oct 57</u>	
PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL, JR.</u>		<u>SYKESVILLE, MD.</u>	
22a. BURIAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>10-28-57</u>	<u>London Park</u>	<u>Baltimore, Md.</u>
23 FUNERAL DIRECTOR'S SIGNATURE <u>John N. Haight</u> ADDRESS <u>Sykesville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>10-28-57</u>	24b. REGISTRAR'S SIGNATURE <u>C. Harry Turner</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

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BUREAU V. 31

## CERTIFICATE OF DEATH

10500

Reg. Dist. No. 76

10470

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>				c. LENGTH OF STAY IN 1b <u>40 YRS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>228 E. MAIN ST.</u>				d. STREET ADDRESS <u>228 E. MAIN ST.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNIE VIOLETTA QUINN</u>				4. DATE OF DEATH Month Day Year <u>OCT. 4TH 1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOT KNOWN</u>	
9. AGE (In years last birthday) <u>75?</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house-wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CARROLL CO. MD.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>DAVID H. ZIMMERMAN</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE RING</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>228 E. MAIN ST. WESTMINSTER, MD.</u> <u>MR. BRICE P. QUINN</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Vascular Renal Disease</u> DUE TO <u>Chronic Nephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Nephrolithiasis</u> DUE TO (c) <u>Severe</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u> <u>4-10</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED?</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>March, 1957</u> to <u>Oct 4, 1957</u> , that I last saw the deceased alive on <u>Oct 2, 1957</u> , and that death occurred at <u>2:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William Speicher M.D. Westminster Md</u>				ADDRESS (Street, city or town, state) <u>10/5/57</u> DATE SIGNED			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>OCT. 7, 57</u>		<u>WESTMINSTER CEM. WESTMINSTER, MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr. Westminster Md</u>				24a. REC'D BY REGISTRAR <u>10-6-57</u>		24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

OCT 2 1937

BUREAU V. S.

10502

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>Since 6-18-35</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>Meadow Road</b>	
3. NAME OF DECEASED (Type or print) First <b>ALLEN</b> Middle <b>BENEDICT</b> Last <b>RAY</b>		4. DATE OF DEATH Month <b>October</b> Day <b>15</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>9-29-69</b>
9. AGE (In years last birthday) <b>88</b> yrs.		10. IF UNDER 1 YEAR Months <b>88</b> Days <b>88</b> Hours <b>88</b> Min <b>88</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Yunk</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel Ray</b>		14. MOTHER'S MAIDEN NAME <b>Fannie Lease</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>Yunk</b>	
17. INFORMANT <b>Springfield State Hospital Records.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b>			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>471</b>			
(b) <b>Bronchopneumonia, right.</b>			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
<b>Alcoholic Psychosis, Acute Hallucinosis.</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-18-</b> , <b>1935</b> , to <b>10-15</b> , <b>1957</b> , that I last saw the deceased alive on <b>10-15</b> , <b>1957</b> , and that death occurred at <b>12:02 P.M.</b> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Martin Gross</b>		M.D. <b>Springfield State Hospital</b> <b>10-16-57</b>	
PHYSICIAN'S NAME (Type) <b>Martin Gross, M. D.</b>		<b>Sykesville, Maryland</b> <b>10-16-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Oct. 18, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>10-16-57</b>	
		24b. REGISTRAR'S SIGNATURE <b>C. Henry Edman</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

OCT 18 1957

BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10502 74

10503

CERTIFICATE OF DEATH

Reg. Dist. No. 184

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SYKESSVILLE</b>				c. LENGTH OF STAY IN 1b <b>29 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRINGFIELD STATE H</b>				d. STREET ADDRESS <b>211 West Belair</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>J</b> Last <b>REEVES</b>				4. DATE OF DEATH Month <b>OCT</b> Day <b>17</b> Year <b>1957</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 17, 1878</b>	
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>			
11. BIRTHPLACE (State or foreign country) <b>NEW JERSEY</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>CHARLES JONES</b>				14. MOTHER'S MAIDEN NAME <b>EMMA SHEPHERD</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-</b> (If yes, give war or dates of service) <b>-</b>				16. SOCIAL SECURITY NO. <b>-</b>			
17. INFORMANT <b>RECORD AT</b>				Address <b>SPRINGFIELD S.H.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-RESPIRATORY INSUFFICIENCY</b> INTERVAL BETWEEN ONSET AND DEATH <b>HOURS</b>							
DUPLICATE DUE TO <b>ANTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> YEARS							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>INVOLUTIONAL MELANCHOLIA</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>-</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>-</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>19</b>				(County) <b>19</b>		(State) <b>19</b>	
21. I certify that I attended the deceased from <b>MAR, 28, 1928</b> to <b>OCT, 17, 1957</b> , that I last saw the deceased alive on <b>OCT, 17, 1957</b> , and that death occurred at <b>3:15 PM</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>SPRINGFIELD STATE HOSPITAL SYKESSVILLE MD.</b> DATE SIGNED							
SIGNATURE <b>Gertrud Sonnenfeldt M.D. Springfield State Hospital Sykesville Md.</b>							
PHYSICIAN'S NAME (Type) <b>Gertrud SONNENFELD M.D. Springfield State Hospital Sykesville Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/20/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cold Spring Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cold Spring, New Jersey</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Tarrington</b>				ADDRESS <b>Aberdeen, Md.</b>		24a. REC'D BY REGISTRAR <b>Oct 19-57</b>	
24b. REGISTRAR'S SIGNATURE <b>Harry H. Stevens</b>							

RECEIVED

OCT 22 1957

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RECEIVED

NOV 2 1957

BUREAU V. M.

# BALTIMORE STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

## 10505

## CERTIFICATE OF DEATH

Reg. Dist. No. 10504

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Balto. City</u></span>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>8 mos. 10 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>2513 N. Charles Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Irma</u> Middle <u>Lee</u> Last <u>Wimbrow RICHARDSON</u>				<b>4. DATE OF DEATH</b> Month <u>October</u> Day <u>9</u> Year <u>1957</u>					
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>June 6, 1890</u>		<b>9. AGE</b> (In years less birthday) <u>67</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u> IF UNDER 24 HRS: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Stansburg Wimbrow</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Martha Godfrey</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO</b> <u>218-03-5364B</u>		<b>17. INFORMANT</b> <span style="float: right;">Address</span> <u>Springfield Hospital Records</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Lung abscess</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of lung pending microscopic findings</u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.B.S. associated with cerebral arteriosclerosis with psychotic reaction. - Rheumatic heart disease.</u>								INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>  <u>Unknown</u>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)					
<b>20c. TIME OF INJURY</b> Month <u>  </u> Day <u>  </u> Year <u>19</u> Hour <u>  </u> a. m. <u>  </u> p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I attended the deceased from</b> <u>January 29, 1957</u> , to <u>October 9, 1957</u> , that I last saw the deceased alive on <u>October 9, 1957</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u> DATE SIGNED <u>10/10/57</u>									
<b>ACTUAL SIGNATURE</b> <u>Walther H. Sonnenfeldt</u>				<b>PHYSICIAN'S NAME (Type)</b> <u>Walther H. Sonnenfeldt, M.D.</u>				<u>Sykesville, Maryland.</u>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Buried 10-12-57</u>		<b>22b. DATE THEREOF</b> <u>10-12-57</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Woodward Park</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Baltimore, Md.</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Wm. Cook, Inc.</u>				<b>ADDRESS</b> <u>1217 N. South St. Balto.</u>		<b>24a. REC'D BY REGISTRAR</b> DATE <u>10-10-57</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>C. Henry Miller</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

OCT 14 1957

BUREAU W. F.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**10506 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

10505

74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN TB <b>1yr. 1mo. 10 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middletown</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>RFD #2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Alta</b> Middle <b>Kate</b> Last <b>Gardner</b> <b>RIDENOUR</b>				4. DATE OF DEATH Month <b>October</b> Day <b>15</b> Year <b>19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>January 20, 1886</b>		9. AGE (In years last birthday) <b>71 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Asst. Postmistress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George C. Gardner</b>				14. MOTHER'S MAIDEN NAME <b>Amanda Bidle</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>410X</b> DUE TO <b>Rheumatic heart disease with mitral and aortic stenosis.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>C.B.S. assoc. with circ. dist., with cerebral arteriosclerosis, with psychotic reaction.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Years.</b>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-</b>		20f. (City or town) (County) (State) <b>- - -</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>James T. Marsh</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>James T. Marsh, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>10/18/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Middletown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gladhill Co.,</b>				24. REC'D BY REGISTRAR <b>DATE 21 1957</b>			
				24b. REGISTRAR'S SIGNATURE <i>C. Harry Myers</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED  
OCT 10 1944  
BUREAU W. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10506 16

10507

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Finksburg</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Finksburg x2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Westminster Road</b>		d. STREET ADDRESS <b>Westminster Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Virginia</b> Last <b>Rook</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>26</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 5, 1876</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Penna.</b>	
11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Paul Rook</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Ritter</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Emory D. Rook, Finksburg, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic C-V Disease</b> DUE TO (c) <b>7 yrs.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>20 min.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hemiplegia, left</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. p. <b>no</b> 19 p. m. <b>no</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <b>none</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>none</b>	
21. I certify that I attended the deceased from <b>1-8-48</b> , 19____, to <b>10-26-57</b> , that I last saw the deceased alive on <b>10-22-57</b> , 19____, and that death occurred at <b>10:10 P.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6 Hanover Rd.</b> DATE SIGNED <b>10-28-57</b>			
ACTUAL SIGNATURE <b>Z. Z. Caples</b>		M.D. <b>6 Hanover Rd.</b>	
PHYSICIAN'S NAME (Type) <b>D. D. Caples, M. D.</b>		Reisterstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Oct. 29/57</b>	22c. NAME OF CHURCH OR CREMATORY <b>St. Paul United Brethren Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Myersville, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. Eline &amp; Sons, Reisterstown, Md.</b>		24. REC'D BY REGISTRAR DATE <b>10-28-57</b>	
24b. REGISTRAR'S SIGNATURE <b>Mary B. Eline</b>		24c. REGISTRAR'S SIGNATURE <b>Shirley M. Eline</b>	

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OCT 20 1957

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10508 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10507

Item 3: G 222 10/28/57 L

# CERTIFICATE OF DEATH

Reg. Dist. No. 174

1. PLACE OF DEATH a. COUNTY <i>Carroll County</i> <i>SPRINGFIELD HOSPITAL</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>CARROLL COUNTY</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SYKESVILLE MD</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SYKESVILLE</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>SPRINGFIELD STATE HOSPITAL</i>		d. STREET ADDRESS <i>ROUTE 3 SYKESVILLE MD</i>	
3. NAME OF DECEASED (Type or print) First <i>RUTH</i> Middle <i>MARY ANN</i> Last <i>ROSS</i>		4. DATE OF DEATH Month <i>October</i> Day <i>6</i> Year <i>1957</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-18-27</i>
9. AGE (In years last birthday) <i>79</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>HOME</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>REUBEN HENRY</i>		14. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>unk.</i>		16. SOCIAL SECURITY NO. <i>unk.</i>	
17. INFORMANT <i>HOSPITAL RECORDS</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular accident</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>CBS associated w cerebral arteriosclerosis</i> DUE TO <i>with Psychotic Reaction.</i> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>July 1, 1956</i> to <i>Oct. 6, 1957</i> , that I last saw the deceased alive on <i>Oct. 6, 1957</i> , and that death occurred at <i>10:55 P.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Gertrude Soumerville M.D. Springfield State Hospital Sykesville Md.</i>			
PHYSICIAN'S NAME (Type) <i>Gertrude Soumerville M.D. Springfield State Hospital Sykesville Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>10-9-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St. Michaels</i>	22d. LOCATION (City, town, or county) (State) <i>Poplar Springs, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Gertrude H. Knight</i>		24a. REC'D BY REGISTRAR <i>10-7-57</i>	24b. REGISTRAR'S SIGNATURE <i>B. H. Knight</i>

RECEIVED

OCT 14 1957

BUREAU V. B.

10509

10508

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>20 yrs. 11 months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>Christian</b> Last <b>Schmitt</b>				4. DATE OF DEATH Month <b>October</b> Day <b>27</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 20-1882</b>	
9. AGE (In years birthday) <b>74</b>		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Meat Cutter</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John A. Schmitt</b>				14. MOTHER'S MAIDEN NAME <b>Mary Young</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO			
17. INFORMANT <b>Hospital records.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b>							
not DUE TO <b>Arteriosclerosis Heart Disease</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Arteriosclerosis</b>							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Epilepsy without psychosis</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>10-16-</b> <b>1957</b> , to <b>10-27-</b> <b>1957</b> , that I last saw the deceased alive on <b>10-27-</b> <b>1957</b> , and that death occurred at <b>4:23 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Agustin del Campo</b>				ADDRESS (Street, city or town, state) <b>Springfield State Hospital.</b>			
DATE SIGNED <b>10-27-57</b>							
PHYSICIAN'S NAME (Type) <b>Agustin del Campo. M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 30, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Elsworth Ormrod</b>				ADDRESS <b>4600 Liberty Heights Avenue</b>			
24a. REG'D BY REGISTRAR <b>Oct 31 1957</b>				24b. REGISTRAR'S SIGNATURE <b>C. Harry Weer</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

OCT 24 1957

BUREAU V. S.

10510

## CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>7 y 1 m 24 d</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>3010 Littleton Road</b>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Schoenrock</b> Last <b>Schoenrock</b>				4. DATE OF DEATH Month <b>10</b> Day <b>11</b> Year <b>1957</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>12-2-72</b>		9. AGE (In years last birthday) <b>84</b> yrs	10. IF UNDER 1 YEAR: Months <b>10</b> Days <b>11</b> Hours <b>19</b> Min. <b>57</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>barber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hair Cutting</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Michael Schoenrock</b>				14. MOTHER'S MAIDEN NAME <b>Mary Volhart</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes</b>		16. SOCIAL SECURITY NO. <b>44-1-1111</b>		17. INFORMANT <b>S.S. Hospital Records</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Bronchopneumonia</b> <b>491</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <b>Senile Psychosis-Agitated depressed Type</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10-20</b> , 19 <b>54</b> , to <b>10-11-57</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>10-11-</b> , 19 <b>57</b> , and that death occurred at <b>11</b> P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Edmund Lusthaus</b>				ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>		DATE SIGNED <b>10-12-57</b>	
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus</b>				Sykesville, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-14-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Vincent</b>		22d. LOCATION (City, town or county) (State) <b>Howard Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur H. Thigert</b>				ADDRESS <b>Sykesville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>10-12-57</b>	
				24b. REGISTRAR'S SIGNATURE <b>C. Harry</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 18 1911

RECEIVED

10511

CERTIFICATE OF DEATH

Reg. Dist. No. 105104

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>2 months 26 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. STREET ADDRESS <b>formerly of: 4108 Amos Ave.</b>			
3. NAME OF DECEASED (Type or print) First <b>May</b> Middle <b>Sheckells</b> Last <b>Sheckells</b>				4. DATE OF DEATH Month <b>10-</b> Day <b>26</b> Year <b>19 57</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 22, 1880</b>	9. AGE (In years last birthday) <b>77</b> yrs	IF UNDER 1 YEAR Months <b>77</b> Days <b>26</b> Hours <b>57</b> Min	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>nurse (rtd)</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>nurse (rtd)</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>			10c. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. FATHER'S NAME <b>Charles Sheckells</b>			12. MOTHER'S MAIDEN NAME <b>Jane Minifee</b>				
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>			14. SOCIAL SECURITY NO. <b>unkn</b>			15. INFORMANT <b>Mrs. Lillian Penn</b> Address <b>3515 Meadowside Rd. #7</b>	
16. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Cholecystitis</b> <b>CBS X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CBS assoc. with cerebral arteriosclerosis with psych. reactions</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>7-30-</b> 19 <b>57</b> to <b>10-25-</b> 19 <b>57</b> that I last saw the deceased alive on <b>10-25-</b> 19 <b>57</b> , and that death occurred at <b>6:36 A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Edmund Lusthaus</b>			ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>			DATE SIGNED <b>10-26-57</b>	
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus</b>			SYNOPSIS <b>Sykesville, Maryland</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/30/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>WM. J. TICKNER &amp; SONS</b>			B.P.B. ADDRESS <b>Balto. 17, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>10/30/57</b>	24b. REGISTRAR'S SIGNATURE <b>C. Harry Sharp</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 24 1957

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10512

## CERTIFICATE OF DEATH

Reg. Dist. No.

105134

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>9yrs. 3mos. 23days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Libertytown</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>Mariah</b> Last <b>SMITH</b>				4. DATE OF DEATH Month <b>October</b> Day <b>4</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 19, 1862</b>	
9. AGE (In years last birthday) <b>94</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>			
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Springfield Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive cardiovascular disease</b> DUE TO (c) <b>Years</b>				INTERVAL BETWEEN ONSET AND DEATH <b>one week plus</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senile psychosis, simple deterioration in a schizophrenic of long standing.</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>July 1, 1950</b> , to <b>October 4, 1957</b> , that I last saw the deceased alive on <b>October 4, 1957</b> , and that death occurred at <b>9:20A M.</b> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>				DATE SIGNED <b>10/4/57</b>			
ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M.D.</b>				<b>Sykesville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>10-8-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Not a funeral home</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank J. Howell, Sykesville, Md.</b>				24a. REC'D BY REGISTRAR <b>DATE 10/9/57</b>		24b. REGISTRAR'S SIGNATURE <b>C. Harry Sherr</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

1957

RECEIVED

10513

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institutions: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>		c. LENGTH OF STAY IN lb <b>187 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>		d. STREET ADDRESS <b>R.F.D. 2, Box 380</b>	
3. NAME OF DECEASED (Type or print) First <b>Louis</b> Middle <b>Stepney, Jr.</b> Last <b>Stepney, Jr.</b>		4. DATE OF DEATH Month <b>October</b> Day <b>30</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 1, 1868</b>
9. AGE (In years last birthday) <b>89</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>A. A. Co., Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Louis Stepney</b>		14. MOTHER'S MAIDEN NAME <b>Janie Allen</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>Louis Stepney, Jr. - Patient</b>	
17. INFORMANT Address <b>Louis Stepney, Jr. - Patient</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular insufficiency</b>		INTERVAL BETWEEN ONSET AND DEATH	
422.1 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) <b>General Arterio-sclerosis</b>	
		(c) <b>Prostatic Hypertrophy</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 26, 1957</b> , to <b>October 30, 1957</b> , that I last saw the deceased alive on <b>October 30, 1957</b> , and that death occurred at <b>10:30 A.M.</b> from the causes and on the date stated above			
ACTUAL SIGNATURE <b>E. M. Maculans</b>		ADDRESS (Street, city or town, state) <b>Henryton, Maryland</b>	
DATE SIGNED <b>10-30-57</b>			
PHYSICIAN'S NAME (Type) <b>Edgars M. Maculans, M.D.; Supt. Henryton State Hospital</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>10/3/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Broadneck</b>	22d. LOCATION (City, town or county) (State) <b>St. Margaret's Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. B. [Signature]</b>		ADDRESS <b>Annapolis</b>	
24a. REC'D BY REGISTRAR DATE <b>10-30-57</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

OCT 21 1937

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 1b <u>11m, 19 d</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Springfield State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Rea</u> Last <u>Tolson</u>		4. DATE OF DEATH Month <u>October</u> Day <u>21</u> Year <u>19 57</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unk</u>
9. AGE (In years last birthday) yrs <u>70?</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Rea</u>		14. MOTHER'S MAIDEN NAME <u>Anne E. -</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unk</u>	
17. INFORMANT <u>Springfield Hospital records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u>			
DUE TO (b) <u>Cerebral arteriosclerosis</u>			
DUE TO (c) <u>Generalised arteriosclerosis</u>			
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CBS assoc with circ. dist. with cerebral arteriosclerosis, with psycho-</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>tic reaction</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>November 2, 1956</u> , to <u>October 21, 1957</u> , that I last saw the deceased alive on <u>October 21, 1957</u> , and that death occurred at <u>6:35 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Elizabeth Kuyopp</u>		DATE SIGNED <u>Springfield State Hosp, Sykesville</u>	
PHYSICIAN'S NAME (Type) <u>Elizabeth Kuyopp</u>		ADDRESS (Street, city or town, state) <u>Springfield State Hosp, Sykesville</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-24-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>West Calverton</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. W. Mearns</u>		24a. REC'D BY REGISTRAR <u>10-21-57</u>	
ADDRESS <u>8057 Calverton St.</u>		24b. REGISTRAR'S SIGNATURE <u>C. H. H. H.</u>	

RECEIVED

OCT 21 1957

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10515

## CERTIFICATE OF DEATH

10514

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>4y 8 m 28 d</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 5, Md.</b>	
f. STREET ADDRESS <b>514 Rose Street</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Oversider</b> Last <b>Van Court</b>		4. DATE OF DEATH Month <b>10-</b> Day <b>26</b> Year <b>1957</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-25-67</b>
9. AGE (In years last birthday) <b>90</b>		10. IF UNDER 1 YEAR: Months <b>10</b> Days <b>26</b> Hours <b>19</b> Min. <b>57</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Oversider</b>		14. MOTHER'S MAIDEN NAME <b>Oversider</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>no</b>	
17. INFORMANT <b>S.S.Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b>			
420.0 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chr. brain syndr. assoc. with cerebr. arterioscler. with dist. of circulation</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 20, 1954</b> to <b>Oct. 26, 1957</b> , that I last saw the deceased alive on <b>10-26-1957</b> , and that death occurred at <b>10:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edmund Lusthaus</b>		DATE SIGNED <b>10-26-57</b>	
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus</b>		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 29/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Philip Herwig Sons</b>		ADDRESS <b>2024 Orleans St</b>	
24a. REC'D BY REGISTRAR <b>C. Harry Weir</b>		24b. REGISTRAR'S SIGNATURE <b>C. Harry Weir</b>	
DATE <b>OCT 30 1957</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU

OCT 30 1957

RECEIVED



1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10515  
74

10516

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>7 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> 155	
3. NAME OF DECEASED (Type or print) First <b>Frederick</b> Middle <b>Stewart</b> Last <b>VERMILLION</b>		4. DATE OF DEATH Month <b>October</b> Day <b>24</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 29, 1873</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Garage employee</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Wash., D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b>			
DUE TO (c) <b>C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>October 17, 1957</b> , to <b>October 24, 1957</b> , that I last saw the deceased alive on <b>October 24, 1957</b> , and that death occurred at <b>2:50P</b> M, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>		DATE SIGNED. <b>10/24/57</b>	
ACTUAL SIGNATURE <b>Agustin del Campo</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		<b>Sykesville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10/28/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>	22d. LOCATION (City, town, or county) (State) <b>Colmar Manor Maryland.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>GEIER FUNERAL Home</b>		24a. REC'D BY REGISTRAR <b>3605 14th St NW</b>	
ADDRESS <b>WASH D.C.</b>		24b. REGISTRAR'S SIGNATURE <b>C. Harry Steery</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. E.

OCT 28 1957

RECEIVED

Reg. Dist. No. 74

# CERTIFICATE OF DEATH

## MEDICAL CERTIFICATION

RECEIVED

RECEIVED BY THE BUREAU OF THE ARMY AND NAVY

BUREAU Y. S.

10518

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MANCHESTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>3 yrs.</u>		d. STREET ADDRESS <u>4311 Grandview Ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Longview Nursing Home</u>		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>GLENN</u> Middle <u>TB.</u> Last <u>WATERS</u>		4. DATE OF DEATH Month <u>October</u> Day <u>20</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 17, 1885</u>
9. AGE (In years last birthday) <u>72</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Contractor Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>West. Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George WATERS</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Williams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-45-9445</u>	
17. INFORMANT <u>Mr. Harold L. Waters - 4311 Grandview Ave.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> DUE TO (b) <u>Arterio-Sclerotic Cardio-Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Parkinson's Disease</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that I attended the deceased from <u>Dec 11</u> 19 <u>54</u> , to <u>October 20</u> 19 <u>57</u> , that I last saw the deceased alive on <u>October 17</u> 19 <u>57</u> , and that death occurred at <u>4:30 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.		ADDRESS (Street, city or town, state) <u>Hampstead Md</u> DATE SIGNED <u>10-20-57</u>	
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush M.D.</u>		<u>HAMPSTEAD Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/23/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Pk.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>WM. J. TICKNER &amp; SONS - Balto. 17, Md.</u>		ADDRESS <u>BALTO</u>	
24a. REC'D BY REGISTRAR <u>DATE 10/24/57</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. H. S. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 22 1907

RECEIVED

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

16

FOR STATE  
HEALTH DEPT.

10519

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL) <u>Palapasco</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>2 wks.</u>		d. STREET ADDRESS <u>363 S. Conkling St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RE. DE. CLF. ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF <u>BERNARD F. WIENHOLD</u> (Type or print) First Middle Last		4. DATE OF DEATH <u>Oct 15 1957</u> Month Day Year	
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-10-05</u>
9. AGE (In years last birthday) <u>52</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HANDYMAN</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>BERNARD WIENHOLD</u>		14. MOTHER'S MAIDEN NAME <u>SUSANNA GRESS.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>_____</u>	
17. INFORMANT <u>CATHERINE HUTH</u>		Address <u>1308 S. BAYLIS ST.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>_____</u> (c), stating the underlying cause last. DUE TO <u>_____</u> (c) <u>_____</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>_____</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James T. Marsh</u>		DATE SIGNED <u>10/15/57</u>	
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL Specify <u>BURIAL</u>	22b. DATE THEREOF <u>10-18-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART OF MARY CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>GERMAN HILL RD., MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles J. Zeiler</u>		24a. REC'D BY REGISTRAR <u>Harriet Miller</u>	
ADDRESS <u>901 S. CONKLING ST. BALTO., MD.</u>		DATE <u>10/18/57</u>	

BUREAU V. S.

OCT 27 1957

RECEIVED



10520

## CERTIFICATE OF DEATH

10519  
Reg. Dist. No. 14

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 13, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>1522 E. Preston Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Orange</b> Middle <b>Dillon</b> Last <b>Wolfe</b>		4. DATE OF DEATH Month <b>10</b> Day <b>5</b> Year <b>1957</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-11-76</b>
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Preacher</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Ohio</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Thomas Wolfe</b>	
14. MOTHER'S MAIDEN NAME <b>Elizabeth Eley</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>u n k n</b>	
16. SOCIAL SECURITY NO. <b>unkn</b>		17. INFORMANT <b>S.S. Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH years _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chr. brain syndr. assoc. with cerebral arterioscler. with psych. reaction</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>8-15-1957</b> , to <b>10-5-1957</b> , that I last saw the deceased alive on <b>10-5-57</b> , 19 _____, and that death occurred at <b>10:15 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Edmund Luthaus</b>		M.D. <b>Springfield State Hospital</b> <b>10-5-57</b>	
PHYSICIAN'S NAME (Type) <b>Edmund Luthaus</b>		<b>Sykesville, Maryland.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-8-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Memorial Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>E, kridge, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>		24a. REC'D BY REGISTRAR DATE <b>10-5-57</b>	
24b. REGISTRAR'S SIGNATURE <b>C. Henry Allen</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		65		M		W		JAN 15 1892		BANGOR, ME	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
1000 BANGOR ST.		LABORER		HEART DISEASE		NATURAL		OCT 10 1957		BANGOR, ME	
FATHER		MOTHER		SPOUSE		CHILDREN		EDUCATION		RELIGION	
JAMES H. HARRIS		MARY H. HARRIS		JANE H. HARRIS		JOHN H. HARRIS		HIGH SCHOOL		METHODIST	
DATE OF INTERVIEW		BY		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
OCT 10 1957		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

BUREAU V. 2

OCT 8 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10521

CERTIFICATE OF DEATH

10520

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>10mos. 23days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>Charles</b> Last <b>WOLVERTON</b>				4. DATE OF DEATH Month <b>October</b> Day <b>29</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 27, 1883</b>	9. AGE (In years birth day) yrs. <b>74</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unk</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Scott Wolverton</b>				14. MOTHER'S MAIDEN NAME <b>- Bowers</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>unk</b>		17. INFORMANT <b>Springfield State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>491x</b> IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral</b> <b>309x</b> <b>Generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>DUE TO</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with circ. dist. with cerebral arteriosclerosis, with psychotic reaction.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>Years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 6, 1956</b> to <b>October 29, 1957</b> , that I last saw the deceased alive on <b>October 29, 1957</b> , and that death occurred at <b>3:15 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>10/29/57</b>							
ACTUAL SIGNATURE <b>Agustin del Campo</b> M.D.				PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b> <b>Sykesville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
<b>Burial</b>	<b>11-1-57</b>	<b>Oakland</b>		<b>Oakland Garrett Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Baldwin James Home - Oakland, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>10/30/57</b>		24b. REGISTRAR'S SIGNATURE <b>C. Navy</b>	

CERTIFICATE OF DEATH

BUREAU Y. B.

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RECEIVED